

**Department of Mental Health (DMH)  
Mental Health Services Act (MHSA)  
Stakeholder Input Process**

**Education and Training Workgroup**

**June 16, 2005 – Sacramento**

**Meeting Summary**

**For Discussion Only**

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## **I. Background**

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed culturally competent mental health system. This is reflected in the California Department of Mental Health's *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

This workgroup was the first of two workgroups on Education and Training to be held over the next few months. Robert Garcia, Chief Deputy Director of DMH, is responsible for the Education and Training component of MHSA. He described the process to-date. MHSA specifically calls for a comprehensive needs assessment and Five-Year Plan for education and training, establishes funding available, and specific roles for the California Mental Health Planning Council, and assigns responsibility for education and training. The Mental Health Planning Council worked with DMH staff member George Bukowski to develop the June 6, 2005 Discussion Paper for the MHSA Education and Training Component, posted on the DMH website. In addition to obtaining feedback from this workgroup, DMH will solicit written feedback and will recruit an advisory committee to review all the feedback and propose priorities for strategies for the required Five-Year Plan. After the priority strategies are developed, another stakeholder workgroup meeting will be convened in the Fall 2005 to provide additional input. The Department expects to recruit and convene an Education and Training advisory committee and has therefore postponed the next scheduled Education and Training workgroup to the fall.

A client and family member (CFM) pre-meeting, held from 9:30 – 11:30 a.m., provided an opportunity for clients and family members to review the afternoon workgroup agenda and provide feedback on education and training issues. The afternoon workgroup meeting was held from 1:00 – 4:00 p.m.

Forty-six (46) people attended the morning CFM pre-meeting and 87 people attended the afternoon workgroup meeting.

## **A. Meeting Purpose**

The purpose of the Education and Training workgroup was to begin the discussion on education and training and to provide DMH with feedback about short- and long-term strategies.

## **II. Client and Family Member Pre-Meeting (9:30 – 11:30 am)**

Forty-six (46) people attended the morning CFM pre-meeting.

### **A. Welcome and Introductions**

Bobbie Wunsch, Pacific Health Consulting Group (PHCG) and facilitator of the MHSA stakeholder process, introduced the client and family member session by providing a quick overview of the workgroup meeting process. The purpose of the workgroups is to provide feedback to the DMH on specific topics. Stakeholders who attend workgroup meetings have special interest, ideas and/or expertise on the topic. The morning client and family member pre-meeting is to orient clients and family members to the afternoon workgroup and to provide an opportunity for specific feedback on issues of interest to clients and family members. A special effort was made at this meeting not to repeat the information to be presented at the afternoon meeting.

### **B. Review of Agenda**

Ms. Wunsch reviewed the agenda for the afternoon workgroup meeting and reminded participants about the concurrent June 23 workgroups on Performance Measurement and IT and on Capital Facilities.

Robert Garcia, Chief Deputy Director DMH, provided a brief overview of the afternoon workgroup topic and introduced the Executive Director of the Mental Health Planning Council, Ann Arneill-Py, Mental Health Planning Council staff Brian Keefer and George Bukowski, the DMH staff member who drafted the discussion paper. Mr. Garcia stressed the importance of client and family member feedback in the process.

### **C. Key Issues in Education and Training for Clients and Family Members**

Sharon Kuehn, Contra Costa County's Office of Client Empowerment and the Client Network, facilitated the feedback process for the morning's session. Participants used a "round robin" process to be able to discuss all topics: participants randomly divided into four groups. Each of four facilitators (Grace Boda, Babs Kavanaugh, Sharon Kuehn and Bobbie Wunsch) recorded brainstorm answers to the four questions below on flip charts as they rotated around through the four groups. In that way, each participant was able to provide input on each question. At the end of the meeting, each facilitator summarized the main points for each question:

1. What changes need to take place in the mental health workforce to encourage, welcome and support clients and family members as employees?

2. What successful strategies have been used (perhaps in your county) to develop peer leadership and peer support programs?
3. What changes would you suggest to better train and prepare licensed and unlicensed professionals to understand wellness and recovery as well as the role of clients and family members as co-workers?
4. What are your ideas about how to prepare and train clients and family members to be providers of mental health services?

### **Client and Family Member Feedback**

1. **What changes need to take place in the mental health workforce to encourage, welcome and support clients and family members as employees?**

### ***Work Environment Accommodations***

- Open new positions for clients and family members
- Actively recruit clients and family members
- Provide extended hours of operation to enable time for consumer employees to see clients and have their own personal appointments
- Provide flexibility and accommodation for disabilities, especially people with multiple disabilities. This includes providing a flexible work schedule so that client and family member staff can continue to meet their family responsibilities.
- Educate employers about the Americans with Disabilities Act (ADA) as it applies to ongoing accommodations for mental health needs (e.g., space, flexible hours, service animals, work from home, mental health days, and time for appointments)
- Have effective Employee Assistance Programs (EAPs) for all staff, not just for consumers
- Have a greeter to direct clients and family members where to go

### ***Work Environment Policy Changes***

- Provide equal pay for equal work
- Create a client-developed Board of Ethics for client and family member employees that could address such issues as dual relationships (consumer staff who know their clients personally), confidentiality of consumer identities and other issues relating to consumer staff

### ***Attitudes***

- Make it safe for staff to express all feelings without retribution, using an Office of Consumer Empowerment or Consumer Affairs and including full-time consumer advocates on the management team
- Make concerted efforts to battle stigma and discrimination inside and outside the system

- Refocus staff/client relations to human relations

### ***Community-Based Organizations***

- Make supports for client and family member staff part of the contractual expectations of community-based organizations
- Ensure that service provider agencies value the input of clients and family members and the values of and expertise in wellness and recovery for the whole system

### ***Mentoring***

- Provide peer mentoring to support transition from Institutions for Mental Disease (IMD) or Board and Care facilities to the community
- Establish opportunities for professional-client mentoring to break barriers and increase understanding

### ***Career Ladder***

- Partner with community colleges to create and market a career ladder for clients and family members in the mental health system
- Develop career ladder of jobs for clients that does not involve participating in involuntary treatment of their peers

### ***Training Topics and Methods***

- Train existing staff about the recovery model
- Train clients and family members about policies, workplace environment, mental health system, etc.
- Train existing staff, clients and family members in cultural competence
- Train staff, clients and family members to not give up on people who choose not to take medications
- Use UACC's and DMH/Department of Rehabilitation (DOR) cooperative training to reduce stigma and lay the groundwork for client and family member employment

### ***Client and Family Member Involvement***

- Take advantage of cultural and linguistic strengths of clients and family members to outreach to all community members
- Place clients and family members in positions to train professionals and demonstrate their knowledge and experience
- Do not penalize counties already hiring and supporting clients and family members

## **2. What successful strategies have been used (perhaps in your county) to develop peer leadership and peer support programs?**

### ***State and County Support and Commitment***

- Commitment from county mental health directors for peer leadership and peer support programs
- County policies to require contracting agencies to promote peer support and leadership development
- Buy-in from existing county staff that developing peer leadership is an important policy and a goal
- Endorse a Technical Center for Self-Help programs
- Buy-in from state and county vocational rehabilitation offices on training programs for consumer staff
- Reimbursement for client and family member participation in training

### ***Preparing the Work Environment***

- Ensure authentic integration of clients and family members into the system
- Include resources for training when creating jobs or hiring consumers
- Give responsibilities to consumers, rather than providing token employment
- Provide parity in pay and benefits for consumers and family members
- Each county should have consumer liaison position on the department's management team
- Establish consumer/executive management positions to develop leadership

### ***Training Methods***

- Create evening and weekend trainings for those clients and consumers who work
- Provide trainings at multiple sites and within community-based organizations
- Hold statewide client conference for peer support to establish system of support across counties and State. Request MHSA funding and support for consumers to participate. Work with participants to replicate the conference at the county level.
- Hold a similar peer support conference with similar benefits for family members
- Hold conferences and seminars to learn about best practices and foster development of peer support programs
- Conduct web-based Internet trainings run by clients and family members

### ***Preparing the Environment for Client and Family Member Leadership***

- Conduct a peer-run anti-stigma campaign for consumer involvement
- Use drop-in centers to provide training and peer support in multiple languages, for all genders, without prejudices
- Create ways to tell client and family member success stories

- Promote local discussion groups to support positive/asset model of mental health success. Provide consumers the opportunity to share what they have learned from their experiences.
- Develop online newsletter to inform and inspire consumers

### ***Existing Training Programs***

- UACC training is a gateway into opportunities for leadership training
- NAMI 12-week family-to-family trainings are attended by consumers as well as family members to learn about the range of mental illnesses
- NAMI offers a 9-week peer-to-peer training
- CASRA offers a curriculum for CPRP certification
- Andrew Phelps, Ph.D., has developed an extensive training module for clients to provide training to mental health staff.
- There are four technical centers that specialize in advocacy training. Three are national, and one, the Client Network in California, is statewide.

### ***Build and Expand on Current Resources***

- Use local mental health boards and consumer advisory boards to develop leadership in local advocacy efforts
- Actively market the development of the programs with participation from consumer councils
- Foster partnerships between counties and community-based organizations to develop and expand peer support programs

### ***Training Topics and Curriculum Design***

- Provide peer-to-peer mentor training
- Conduct empowerment trainings
- Engage consumers in the curriculum design for conferences and trainings on wellness and recovery

### ***Examples of County Programs***

- Contra Costa County
  - SPIRIT Program: Training and internship program for consumers to become providers. Wellness Recovery Action Plan (WRAP): Ten-week support group.
- Los Angeles County
  - Mental health consumer training for self-help organizations. Resources for development and ongoing support for self-help groups.
  - Allocation of training dollars to consumers. Consumers design the training.
  - Consumers are integral to MHSA implementation. Consumers make presentations with MHSA staff on the wellness and recovery model.
  - Training program for consumers to develop as peer mentors.
- San Bernardino County

- Network of consumer-run clubhouses for social activities, training and peer support. Clients develop and teach classes on topics such as life skills and benefits counseling, do the cooking and provide a space for social interaction.
- City and County of San Francisco
  - Peer leadership development program for ethnically diverse communities. Contact Tina Yee.
- San Joaquin County
  - Fifteen-week employment program for consumers to prepare them for employment. County Mental Health partners with DOR. This program has resulted in an increase in the number of consumers employed by the county.
  - Program to teach more skills for independent living.
  - Power of Support: Program to build self-esteem, and learn about self-help. Consumer-run newsletter that promotes the consumer voice and records success stories.
  - Gibson Center: support center where life skills are taught. Consumers work in volunteer positions as they gain skills to move into paid positions.
- Stanislaus County
  - Received financing and grant funding for self-help and peer support programs.
- Trinity County
  - The Client Network and the County partner in the self-help resource center.

### ***Rural and Small County Issues***

- Focus on rural counties, where training is needed
- Provide mobile training to reach rural and isolated areas
- Provide peer support training to local staff

### **3. What changes would you suggest to better train and prepare licensed and unlicensed professionals to understand wellness and recovery as well as the role of clients and family members as co-workers?**

#### ***Clients and Family Members***

- Best training is to have consumers and family members model work at all levels – administration, clinical, line staff – a guaranteed “stigma buster”
- Remove glass ceilings for clients and family members: the sky is the limit in terms of opportunities in mental health and other areas
- Include clients and family members in training professionals at educational institutions, workshops and community trainings, providing their viewpoints and experiences
- Curriculum changes require more than “wordsmithing.” The key is the experiences and knowledge of the teacher and trainer.
- Peer-to-peer training is essential: it shows consumers and family members, “I can do it too!”
- Support paid internships for consumers and family members
- Identify better ways to publicize training programs broadly throughout community

- Have consumers talk about their own recovery, telling personal stories in trainings
- Use *promotores* as trusted ambassadors in communities of color
- Encourage people of color to become more involved in training. Outreach to all parts of the community.

### ***Types of Training and Topics***

- Change philosophy of training from medical model to wellness and recovery
- Explore changes in how relationships and professional ethics change as the role of client and family member as employees grows and expands
- Assure buy-in to recovery and psychosocial rehabilitation model in training and education
- County mental health can provide training to other community agencies, such as law enforcement and schools, using clients and family members as part of the training team
- Develop trainings jointly with client and family member workers and other workers
- Explore and review local education and service training programs so they can “model” wellness and recovery philosophy
- Include history of consumer movement, self-help, peer support and client culture as part of educational curriculum
- Include mental health perspectives in health education training curriculum
- Include information on co-occurring disorders in training
- Include information on advance directives for clients in curriculum

### ***Universities, Community Colleges and Other Educational Institutions***

- Some universities have field of Disabilities Studies. This could be a tool to help clients and family members branch into other fields in addition to mental health.
- Teams of clients and family members could shadow mental health professionals and vice versa. Field placements could be used to promote better understanding. This works well for new professionals.
- Negotiate with academic institutions to incorporate wellness and recovery into academic curriculum for different professions
- Partner with academia for internships and field placements, to heighten awareness and sensitivity for new professionals. Change requirements for field experience to promote awareness of recovery and wellness.
- Partner with Regional Occupation Programs (ROP) and community colleges to incorporate mental health perspectives in trainings
- Enhance credentialing programs to include clients and family members in training programs both as participants and as trainers
- Have clients and family members run college classes for community members, clients, family members and professionals. They could provide general mental health overview. This could lead to certificate programs, to diplomas and to graduate work.

- High schools and colleges should offer general education on mental health for stigma reduction. Sacramento, Los Angeles, San Mateo, Contra Costa and Stanislaus are counties with good models for doing this.
- Target training for teachers of young children in elementary schools and child care centers with mental health awareness training

### ***Attitude Changes in Work Settings***

- Employment setting must be “model” of positive philosophy and wellness and recovery
- Make wellness and recovery training mandatory for supervisors
- Diminish the disconnect between recovery and wellness and work settings
- Implement top-down philosophy to support clients and family members as coworkers and make sure that top administrators “model” philosophy
- Need to un-learn previous training about abilities of mental health clients: “unproductive workers,” “cannot function in workplace,” “cannot be flexible” messages and retrain professionals in wellness and recovery
- Identify what current staff have in common with consumers to break down barriers

### ***New Staff/Professionals***

- Provide orientation for new staff to get to know peers’ personal experiences
- Pipeline is integrated with clients and family members and non-client and family member professionals
- Expose new professionals to cultural diversity and cultural competence and wellness and recovery
- Review use of language to support shift to wellness and recovery model
- Provide anti-stigma training

### **4. What are your ideas about how to prepare and train clients and family members to be providers of mental health services?**

### ***Training Topics and Target Groups***

- Teach people how to use their personal experience to help others
- Bruce Anderson’s “Core Gifts” training to help people identify what they want to contribute and to discover their own individual meaningful role
- Cover a range of issues for training: dealing with authority figures, confidentiality, working as a member of a team, dealing with cultural and other discrimination, setting limits and understanding the role of consumer/provider
- Educate about culture of the workplace (e.g. medical model and politics)
- Train people for supervisory, management and administrative positions
- Train on computer skills, money management and time management, communication skills (including how to speak up at meetings), how to advocate for themselves and their family

- Include orientation with complete system overview as well as local, regional and statewide networking opportunities
- Train on local, regional and statewide legal issues: compliance, audits, rules and regulations
- Sponsor training for counties on legal issues of working with people on federal or state supplemental security income (SSI or DSSI). Counties must understand work incentives and the effects of pay (through stipends or more) on the consumer's SSI or DSSI benefits so that the consumer employee does not lose anticipated income.
- Disseminate information to consumers to make them aware of support resources on college campuses such as Disabled Students Services (DSS) and what reasonable accommodations are available to them as students
- Train youth about independent living, coping skills, employment assistance with entering community college
- Train and support people who have been incarcerated and their families
- Provide training to Mental Health Boards
- Open all topics to all staff, not just clients and family members

### ***Training Methods***

- Provide real life experience such as immersion training in homelessness
- Offer different options for training: brief academic training or certificate programs and degrees
- Design training to build consumers' self-esteem and raise expectations. Training group can develop healing relationships.
- Train clients, family members and providers together about how to work together
- Create mentorship programs that pair people up to learn about other disabilities, or that pair consumer/providers with more experienced providers
- Start training preparation early by bringing information to inpatient units
- Provide in-service trainings for consumers and family members who learn better experientially than academically

### ***Preparing the Workplace Environment***

- Integrate peer support into management, administration and supervisory positions
- Have clear job descriptions for clients working in county mental health to ensure meaningful direct work with clients and valued input to the team
- Provide opportunities for clients who work in the mental health system in a region to come together to support each other and brainstorm solutions to consumer issues
- Create a safe environment in current workforce for self-disclosure as clients
- Improve communication flow among existing staff
- Use outcomes measures on staff satisfaction: use satisfaction survey results to guide changes
- Shift from supported employment to employment, focusing on work, not treatment
- Create entry-level stipend positions to encourage clients on benefits to try working, such as volunteer jobs with flexible training

- Provide benefits counseling so that clients do not lose benefits when entering the workforce

### ***Client and Family Member Involvement and Support***

- Encourage consumers to participate to build stronger mental health services
- Start consumers on the road to employment through consumer-friendly support meetings (explore interests, goals, etc.)
- Provide financial aid for consumers who want to go to college
- Provide transportation support for clients and family members to attend trainings
- Provide incentives for participation
- Establish a bridge fund to support people who try to return to work but need to resume benefits or to cover a gap
- Establish a fund for clients to obtain work wardrobes
- Allow flexible training at one's own pace to accommodate intermittent health issues, valuing momentum and allowing "stepping out" for a period of time
- Develop a client-to-client course to establish ongoing support for clients who are working
- Hire consumer-providers to act as liaisons to help people access community resources

### ***Model Programs***

- CMHDA/CIMH Leadership Training for clients and family members to attend as a committee from their county. Provide stipends to participate.
- CASRA curriculum and CPRP training provide solid preparation for clients and family members
- NAMI's family-to-family course covers many of requested topics for coping and understanding the system; NAMI also offers group facilitators training for consumers advocating recovery through empowerment
- Contra Costa County's SPIRIT program provides training for consumers to become providers. Include financial support to allow participation through a scholarship fund.
- Sac-PORT training led by and for consumers in skill building uses the work of Dr. Lieberman from UCLA

### ***Career Ladders***

- Establish supported access to all levels and positions in career ladders
- Tie accountability of educational institutions into the career ladders
- Develop a career ladder with steps to move up and a structure for advancement within organizations

## **III. Education and Training Workgroup Meeting (1:00 – 4:00 p.m.)**

Eighty-seven (87) people attended the afternoon workgroup.

## **A. Welcome, Introductions and Purpose of the Education and Training Workgroup Meeting**

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, welcomed the participants. She clarified the purpose of the workgroup and introduced Robert Garcia, Chief Deputy Director, DMH, who is in charge of the Education and Training component of MHSA.

## **B. MHSA Education and Training Vision, Role of Mental Health Planning Council, Estimated Funding**

Robert Garcia began by introducing the people who helped to develop the Draft Discussion Document on MHSA Education and Training: Ann Arneill-Py, Executive Director and Brian Keefer from the California Mental Health Planning Council, George Bukowski, DMH and Carol Hood, DMH.

The Mental Health Planning Council involvement in the Education and Training element of the MHSA is laid out in the Act itself. The Planning Council is responsible for reviewing and approving the Education and Training Five-Year Plan and advising and providing oversight for the Department's Education and Training plan development. Several years ago, the Mental Health Planning Council recognized education and training as a major priority, documenting it through a series of reports posted on the DMH website. Key findings showed a lack of cultural and linguistic competence in the system, workforce shortages and the profound impact of stigma on recruitment of people entering the mental health field. The Mental Health Planning Council will be a critical partner with DMH in implementing this portion on the MHSA.

DMH is required by the MHSA to conduct a statewide needs assessment and develop a Five-Year Plan. DMH believes the five-year plan must be developed before substantial resources are committed to training and education.

While a follow-up workgroup session was originally scheduled for July 26, DMH has decided to postpone it until Fall. DMH plans to incorporate the feedback from today with other written comments. A broadly representative advisory committee will be created to review the draft needs assessment and plan, which will then be brought back to a stakeholders workgroup for additional feedback. This process will take more time than originally anticipated. However, no major decisions about the Five-Year Education and Training Plan will be made without stakeholder input.

Mr. Garcia then reviewed a portion of the PowerPoint presentation, *Mental Health Services Act Education and Training Workgroup Meeting, June 16, 2005*, which is posted on the DMH website.

## **Major Goals of the Education and Training Element of MHSA**

- Assure adequate workforce for present and future mental health programs
- Sustain quality improvement through educational competencies and involvement of consumers and family members
- Support transformation of workforce with a philosophy of wellness, recovery and resilience
- Support diversity in workforce

## **Estimated Education and Training Funding**

Most of the funding for the Education and Training component will be in the first three years and will decrease over time, so it must be considered mostly one-time.

Therefore, the investments must become self-sustaining. It is estimated that there will be a total of \$324 million between FY 2004-05 and FY 2007-08: \$114 million in FY 2004-05, \$68 million in FY 2005-06, \$69 million in FY 2006-07 and \$73 million in FY 2007-08. After FY 2007-08, up to 20% of MHSA funds each year can be committed to a combination of Capital Facilities, Information Technology, Education and Training and a prudent reserve. No specific limit is set on any one of these elements.

## **Five-Year Plan Options**

According to MHSA, the following types of programs will be included in the Five-Year Plan:

- Expansion of post-secondary education
- Loan forgiveness and scholarships
- Stipend programs
- Regional partnerships
- High school career development and Regional Occupational Programs (ROP)
- Increasing workforce capacity
- Training of new staff
- Training for existing staff
- Promotion of consumers and family members
- Cultural competence training

## **Short-Term Implementation Strategies**

While the majority of the Education and Training funding will not be released pending the approval of the Five-Year Plan, some investments will be made early on. Funding decisions will be based on the following criteria:

- Consistent with MHSA vision and values
- Elements likely to be part of five-year plan
- Should have long-term impact

- Funding should leverage other funds where possible
- Reflect cultural competence
- Involve clients and family members
- Affect all geographic areas of California

### **Examples of Short-Term Strategy**

Potential ideas for short-term strategies including the following:

- Consumer and family member training that can start quickly, does not require a large amount of money and can have a long-term impact
- Stipends to increase the workforce pool, such as stipends to train social workers and the initiation of educational programs to graduate diverse workforce members.  
There is a proposal pending for social work stipends.

### **Developing Needs Assessment and Five-Year Plan**

DMH is considering contracting with an entity that has experience in conducting needs assessments. This will require the development of an RFP and a process to evaluate responses. The needs assessment and five-year plan development process could take up to one year to complete. Requirements for the Five-Year Plan include the following:

- Must track with the vision and values of MHSA
- Must conform to the Education and Training sections listed in the MHSA
- Must be renewed every five years
- Must be approved by Mental Health Planning Council
- Must address public and community-based organizations
- Must address state and county controls on funds

### **Stakeholder Questions and Comments**

#### ***Target Populations for Education and Training***

- California Social Work Education Center (CalSWEC) is in the midst of a two-year initiative to train social work students in recovery and resiliency, evidence-based practices, cultural competence and working with clients and family members to develop programs. Students in the initiative represent California's rich diversity: 39% are white, 32% Latino, 14% African American and 10% Asian. They speak 26 different languages. CalSWEC has been working hard to continuously improve this program and, at the same time, can understand concerns of other stakeholders. CalSWEC has a stipend program in place that will continue, but could bring more people into the pipeline faster with additional assistance from MHSA.
- Existing training for counselors such as drug counselors and school nurses who identify early signs and make referrals is as important as training for social workers.

- **DMH Response (Robert Garcia (RG)):** MHSA talks about stipend programs. DMH has not made any decisions and this one for social work training, which is being considered, is not the only one that will ultimately be funded.
- The stipend issue is important. Narrowing in on social workers is too limiting. Health education specialists are also critical.
  - **DMH Response (RG):** DMH agrees that it needs to think broadly and these ideas need to be included in the mix.
- A lot of consumers will not go to traditional services centers, but may seek help from their priest or others. These people need training in what the available resources are. Outreach and education about resources is essential for clients.
- Certification is important. There is now an understanding that MHSA funding should be used only for voluntary services. If the Education and Training component trains professionals who can 5150 people, this may be a means of getting around the understanding. Establish certifications so that people who do not believe in involuntary services can be trained and not be compelled to commit people. Clients and communities of color can be involved in creating certifications at community colleges.
- It is important to address education at all levels, not just post-graduate, from residential to outpatient programs. The New Careers Programs, which operated successfully in 1971-72, reached out to people from the community, with no degrees or education. Many became mental health workers. This is the type of program that should be replicated.
- Do not forget training of transition-age youth. They may be lost in the process.
  - **DMH Response (Carol Hood (CH)):** Yes, it is critical that transition-age youth are provided training opportunities. As far as MHSA, transition age youth is defined as 16-25, but it varies in different programs.

### ***Education and Training Needs Assessment and Planning Process***

- Do not put the cart before the horse. The needs assessment will only assess the current system. Unless the needs assessment is delayed until the counties have developed their plans, it will be impossible to assess what is needed in the new system. Diversity, consumer involvement and public health inclusion factors need to be included in training programs. The focus must be to apply pressure on the universities to provide training about the recovery and wellness model.
- It is good that DMH is contracting out the planning aspect of education and training. In addition, program evaluation needs to be included at the very beginning, using external evaluators.
- Will there be specific guidelines for counties to follow about cultural competence? Some counties have a history of not implementing and operationalizing their existing cultural competency plans.
  - **DMH Response (RG):** Cultural competence has to be embedded in everything done in education and training, as does consumer and family member involvement. How DMH goes about designing that and how directive the Department is to the counties is a matter of ongoing debate.

- It is important to leverage all the available resources in a community, not just from community-based organizations. For example, some services can be provided in community buildings like a Grange Hall.

### ***Model Programs***

- Develop a fast-track system to admit people to post-graduate programs without as many course pre-requisites.
  - **DMH Response (RG):** That is one of the elements DMH will consider.
- Mark Ragin, a doctor at the Village in Los Angeles has many valuable ideas, laid out in two- to three-page essays.
- UCLA just had a program for artists with disabilities. Many of these artists have a large unmet need for mental health services. CIMH is working to help counties develop art programs that are innovative. The people in the UCLA program are studying how to be advocates of disabilities in terms of employment, within the community. These artists with physical disabilities are informed and way ahead of the mental health community. Bring these people into the advisory group. Reach out to people who are in Disabilities Studies.
  - **DMH Response (RG):** Please send more information.
  - **Stakeholder Response:** Resources include the Society of Disabilities Studies at the University of Chicago and San Francisco State University.

### ***Advisory Committee and Stakeholder Process***

- Leveraging is important, but this is a skewed stakeholder process. It is important to outreach beyond the traditional providers to include education, libraries, community colleges, parks and recreation, etc. An advisory committee for this process is critical. This committee needs to be very broad-based.
  - **DMH Response (RG):** The committee will be inclusive of multiple groups, including client organizations, higher education, community colleges, clients and family members. It will be very broad-based.
- In the pre-meeting, consumers and family members made many suggestions about hiring and integrating clients and family members. Will these suggestions be included on the website?
  - **Pacific Health Consulting Group (PHCG) Response:** A summary of today's pre-meeting will be included in the summary of today's workgroup and will be posted on the MHSA website in one week.
- How will members of this advisory committee be recruited and selected?
  - **DMH Response (RG):** The committee does not exist yet. DMH will contact state organizations and will appoint a broad-based representation.
  - **Stakeholder Response:** Do not just contact the statewide groups, as there are many individuals not part of established groups who would like to participate.
  - **DMH Response (RG):** DMH plans to select a broad group of representatives.

## ***Retraining and Retention***

- It is important to recruit people, but it is essential to focus on retention. In order to retain staff, they need satisfying jobs. Therefore, it is critical to integrate the recovery model. Because this is major change, it must be implemented from top to bottom.
  - **DMH Response (RG):** Retention is important. Training current staff is important as is ascertaining what must be done to keep existing people in the system.
- Training and retraining to transform the mental health system will be the most critical part of the whole process. There must be programs to reorient staff to think differently.

## **C. Short-Term and Long-Term Education and Training Proposed Strategies**

Mr. Garcia next described the potential strategies that could be implemented through the Education and Training component of MHSA. He emphasized that clients and family members were integral to any work and decisions made for education and training. He illustrated how the wording in the MHSA could be turned into action.

Specific program options include the following:

- Financial incentive plans
- Loan forgiveness through potential collaboration with the Health Professions Education Foundation to set up and administer loan and scholarship programs
- Creation of stipend programs, potentially contracting with organizations like CalSWEC
- Establishment of regional partnerships to reach rural communities and communities of color. Strategies could include distance learning.
- Recruitment of high school students into mental health occupations
- Development of curriculum to train and retrain staff
- Promotion of the employment of mental health consumers and family members. Clients and family members will be eligible for MHSA financial incentives, DMH will sponsor development of entry-level training programs and assist counties in developing ways to employ consumers and family members.

## **CFM Pre-Meeting Summary**

Sharon Kuehn presented a summary of the feedback gathered during today's CFM pre-meeting, organized by question.

### ***1. What changes need to take place in the mental health workforce to encourage, welcome and support clients and family members as employees?***

#### ***Prepare the System***

- Train and embody the wellness and recovery model
- Aggressively confront stigma

- Create career ladder for clients and family members
- Ensure equality in pay and positions
- Prepare human resources departments at county and state levels to work with clients and family members
- Create jobs that challenge intellect and skills

### ***Accommodate Needs***

- Train employers about ADA requirements for mental health needs
- Offer flexible work hours
- Permit individual accommodations

### ***Empower Consumers and Family Members***

- Hire full-time advocates and open an Office of Consumer Affairs
- Redefine ethics and roles, addressing such issues as those that have to do with hiring clients and family members, confidentiality, examining rules around dual relationships (people who know their clients personally)

### ***Promote Humanizing Relationships***

- Use clients as trainers, so that they can be seen as whole and competent people
- Promote partnering of existing staff and new consumer and family member staff to increase understanding

## ***2. What successful strategies have been used (perhaps in your county) to develop peer leadership and peer support programs?***

### ***State and County Support and Commitment***

- Policy changes, financial support and technical assistance
- Build and expand on current resources and systems such as local mental health boards

### ***Curriculum Development***

- Designed by clients and family members
- Embeds cultural competence
- Based on wellness, recovery and resilience lens, etc.

### ***Delivery of Training***

- Forums and conferences
- Mobile training with travel to isolated communities
- Web-based

## **Communication**

- Newsletters
- Opportunities to be heard, presenting a positive voice
- Web-based

### **3. *What changes would you suggest to better train and prepare licensed and unlicensed professionals to understand wellness and recovery as well as the role of clients and family members as co-workers?***

- Retrain professionals in concepts of wellness and recovery
- Include clients and family members as trainers and instructors
- Use *promotores* as trusted ambassadors to encourage people of color to become mental health professionals
- Clients and family members as workers modeling wellness and recovery at all levels – administrators, clinic, line staff
- Top administrators must “talk the talk” and “walk the walk”
- Change academic environment and requirements for field placement and internships so they promote understanding and direct experience with wellness and recovery

### **4. *What are your ideas about how to prepare and train clients and family members to be providers of mental health services?***

- Wide range of roles: peer support, professional positions and administration/management
- Training will vary: entry-level preparation from leadership trainings, in-house or community trainings; certificate, community college or CPRP; graduate and post-graduate programs and degrees
- Engage people and have a flexible array to support them. Consumer students/providers should be able to make some progress and step out as needed and not lose everything they gained. Provide scholarship funding.
- Consumers should have a pathway that includes volunteer positions with stipends, benefits and benefits counseling
- Outreach to youth, incarcerated, inpatients, diverse cultures
- All contractors should be required to have such a ladder to include people

## **Stakeholder Questions and Comments**

### **Planning Process**

- In terms of a needs assessment, the Mental Health Planning Council's Human Resources Project did a good job of identifying unmet needs, but looks at the existing system. MHSA demands an out-of-the-box focus on the system we want to create and at the workforce needs for this new system.

- Do not put all of the MHSA eggs in one basket. Look broadly at community colleges. The key words are training, training, training, and lots of it on all levels. Develop online and distance learning and offer scholarships so that more people can participate.
- The funding streams that the counties and state are dealing with are in conflict. The current model is based on the Chrysler building, with professionals with post-graduate degrees. The other, the wellness and recovery model, is more like a quonset hut. They do not fit together. Focus on wellness and recovery. Advocates must train both the federal and state government to fund this focus rather than on illness and keeping people sick.
- Will there be an age limit to those who would benefit from the Education and Training finances and other incentives? Will the older adult again be forgotten in terms of scholarships? Hopefully this will not be true.
- There is a tension between speed and depth as noted in the training by John Ott. We will not get it right the first time. The needs assessment will likely not get it right. Be careful and flexible.
- It is good that the Mental Health Planning Council is involved
- Los Angeles is working with its schools of social work on a stipend program for incoming students. Students have been chosen for next year but no one knows whether they can be supported with MHSA funds. It would be good to know the timing.
  - **DMH Response (RG):** DMH recognizes the urgency and expects to make a decision about stipends for the fall students in the next week or so.

### ***New and Existing Staffing Needs***

- The system will need more psychosocial rehabilitation workers and staff with more cultural diversity
- Recruit former military personnel for mental health professions. They have benefits like the GI Bill. They can provide a diverse and culturally competent workforce. The teacher shortage was addressed using a similar recruitment concept. Show military personnel the opportunities open to them in mental health.
- Do not forget consumers who do not know how to read or write. They need literacy training so they can move forward in their lives and can eventually be able to work in the mental health system.
- Medi-Cal eligibility is discriminatory against consumers. Medi-Cal has limited funding for rehabilitation services so it will be difficult to seek funding for education and training from Medi-Cal.
- Immersion training, in which professionals spend time living on the streets, has been overlooked
- Nothing is more valuable than having a one-on-one mentor assigned to a client

### ***Cultural Competence***

- Instead of “appreciating cultural diversity,” build on cultural strengths

- When thinking about cultural competency, ask how it affects each of the four questions discussed. Listening to the summary of the pre-meeting, it was not possible to pinpoint all the cultural statements. Form an advisory committee to help with workforce training and cultural competence.
- It is crucial to start recruiting for mental health professions before high school, because some ethnic groups have a large group who never make it through high school
- Mental health advocates have struggled to help professionals work with diversity. Now that consumers may become professionals, they will need ongoing diversity training in their new role, in order to work with cultures different from their own.
- Cultural competence is crucial. Los Angeles County spent many hours preparing for its cultural competence audit. It is essential to integrate cultural competence into county plans. Los Angeles has eleven threshold languages to address and all training needs to be specific to each.

#### **D. Small Group Discussions on Short Term and Long Term Strategies for Education and Training Component of MHSA**

DMH requested feedback on five topics related to education and training. Participants self-selected which topic they wanted to discuss. The questions are listed below and can be found on the agenda for June 16 posted on the MHSA website.

##### **Topics:**

- Increase the Licensed Professionals/Nonlicensed Staff in the Workforce
- Increase Consumer and Family Members in the Workforce
- Education and Training for New Staff
- Education and Training for Existing Staff
- Rural and Small County Issues

#### **1. Increase the Licensed Professionals/Nonlicensed Staff in the Workforce**

- 1.a. Which occupations do you think have the highest priorities for workforce development? What are some specific strategies for increasing their numbers?**

##### ***Recovery-Based Staff***

- Outreach and education staff: “a person who markets” support services
- Recovery Life Skills Specialists
- Cultural/Community Broker/Advocate
  - *Strategy:* Work with culturally-specific grassroots organizations. Identify natural leaders in these communities. Use “voices of their community.”
  - *Strategy:* Reorient classification system at county human resources level.
  - *Strategy:* Have stipends in the system and career ladder to climb with supports.

- Employment/Education Specialist
  - *Strategy:* Have stipends in the system and career ladder to climb with supports.
  - *Strategy:* Create greater flexibility with county human resources systems.
- Housing Advocate for Transition-Age Youth, Adults and Children
  - *Strategy:* Develop staff development resources on the career ladder.

### ***Quality Improvement Staff***

- MHSA quality assurance staff
- Outcomes performance analyst

### ***Licensed and Other Staff***

- Psychiatrists and other licensed professionals
- Medi-Cal billing (a rehabilitation option)

### ***Additional Comments***

- The question “what programs do we need to develop based on the needs assessment?” must be answered before it is possible to answer this question
- Workforce will be more stable if staff are well trained and have good skill-sets

**1.b. What strategies would be effective for increasing the ethnic and linguistic diversity of the mental health workforce? Do they differ by occupation, e.g. psychiatry, psychology, social work, nursing, peer self-help counselors, wellness/recovery trainers, respite care staff, etc.?**

### ***Financial Support***

- Ensure equal bilingual pay
- Prioritize stipends

### ***Other Support***

- Assist underemployed immigrant professionals living in U.S. with obtaining licensure and certification
- Develop a database of the skills of individuals working for or associated with mental health
- Develop educational outreach to the community

**1.c. What are the immediate employment development, education and training programs that you would like funded and implemented?**

### ***Training Methods and Programs***

- Develop literacy programs for stakeholders of all age groups

- Support distance learning
- Support CalSWEC proposal to integrate competencies, but also provide stipends for other programs

### ***Anti-Stigma Campaigns***

- Reach out to pre-high school students in an anti-stigma campaign
- Develop education and stigma reduction programs that are specific to individual communities to open the pipeline

### ***Curricula***

- Introduce the CASRA curriculum to the school system
- Support mental health certificate programs, such as CASRA, Pasadena, Best Jobs Now, etc.). These are successful only if human resources systems become flexible and certificates are valued.

### ***Target Groups for Training and Outreach***

- Reach out to students before high school to introduce the idea of mental health professions and support their efforts.

### **1. d. What strategies need to be implemented to ensure consumer and family member involvement in the development of education and training plans?**

### ***Support for Consumers and Family Members***

- Level the playing field to enter the mental health profession
- Change classification systems
- Develop support mentorships for leadership
- Counties and community-based organizations should support consumer and family member advocacy
- Prioritize stipends for consumers and family members

### ***Training of and by Consumers and Family Members***

- Implement leadership development for consumers and family members: a leadership academy developed by CIMH should to be part of budget planning and administration
- Hold seminars in higher education for students where faculty brings in consumers as teachers
- Implement “Jobs Now” and other programs

### ***Inclusion of Consumers and Family Members***

- Outreach to consumers and family members

- Consumers and family members should be on the MHSA Education and Training Advisory Committee

## **2. Increase Consumer and Family Members in the Workforce**

### **2. a. How can consumer and family member employment be increased in county-operated mental health programs and community-based agencies?**

#### ***Human Resources Changes***

- County human resource departments need to be integrated with county mental health departments to address vision, recruitment needs, and classification of consumers and family members
- Classifications need to match the work being done in the public mental health system. They need to reflect the variety of certificated and non-certificated trainings that make one eligible for employment.
- Human resource departments need to make the hiring process easier
- Have job descriptions that identify life experience for a job in addition to more traditional “consumer-identified position”
- County operated programs should set goals for hiring consumers and family members and develop strategies to achieve them
- Ensure equity in pay and responsibilities

#### ***Positions***

- Hire an individual to recruit and train consumers and family members
- Establish a consumer and family advocacy position. Establish cultural competency liaison or ethnic services specialist position. These two positions should work together to engage diverse communities.
- Create positions such as recovery coach, outreach worker, mentors and peer advocates

#### ***Support***

- Enhance peer support and recovery services that are offered so that consumers and family members work in a system that they see working
- Interact with consumer and family groups to identify individuals with a desire and expertise to fill a position
- Provide hope

#### ***Training***

- Provide technical assistance to counties that do not have experience in hiring consumers and family members, such as the Four Steps

- Provide a community skills-building course, such as the one in San Joaquin County, which addresses communication skills, resumé building, emotional support, self-care, stress management, etc.
- Develop programs run by consumers to train consumers to work in peer-run programs, such as Contra Costa County's SPIRIT program

### ***Attitudinal Changes***

- Provide training for county administration and Board of Supervisors
- Institute anti-stigma campaigns to reeducate people that "we're people, too"

### **2.b. What are the skill needs that should be addressed in consumer and family training?**

#### ***Rights and Responsibilities***

- Communication skills: broad-based skills for successful employment throughout the system, entry level to management
- Cultural and ethnic competence and respecting people's differences such as religion and beliefs
- Knowledge of ADA and its accommodations
- Ability to respect other people's rights and viewpoints and having compassion for others
- Understanding of how the system works
- Knowledge of available resources
- Ethics

#### ***Wellness and Recovery***

- Self-care
- Understanding of empowerment and recovery visions
- Principles of psychosocial rehabilitation
- Knowledge of evidence-based practices or promising practices, or emerging, cutting-edge practices

#### ***Training of Existing Staff and Partners***

- Train supervisors to manage the flow of work so that it is meaningful to consumers and family members
- Promote understanding of client culture for existing staff and law enforcement
- Avoid consumer and family member-specific training. Provide training that engages and includes clients and family members.

**2.c. What are the immediate employment development, education, and training programs that you would like funded and implemented?**

***Training Programs, Topics and Methods***

- Community skills-building, offered on a year-round basis, to include such skills as reading and writing, etc.
- Fund peer-run education programs
- Supports for earning GED and literacy training
- Career path responsibilities: identify what training consumers and family members need to advance or to join the workforce
- Volunteer opportunities, including stipend, transportation and food that can move people from volunteer to employment

***Curricula***

- Provide CASRA curriculum in county mental health departments
- Contra Costa County's WRAP program
- DMH/DOR cooperative program
- Expand CIMH training

***Target Groups***

- Offer comprehensive consumer and family member training to become a provider
- Train school-age family members in mental health issues
- Educate youth that mental illness is an illness like physical illness, nothing to be ashamed of
- Offer employment training to Mental Health Boards

***DMH Funding and Policy Changes***

- Urge DMH to recognize Certified Psychosocial Rehabilitation Professional (CPRP) programs
- Provide scholarships for pursuing higher education

**2.d. What strategies need to be implemented to ensure consumer and family member involvement in the development of education and training plans?**

***Inclusion of Consumers and Family Members***

- Hire consumers and family members as staff or contract with them as consultants for planning committees
- Hire consumers at the state and local levels
- Ensure a certain percentage (maybe 50%) of consumers and family members participate in any planning sessions

- Establish 'real' employment opportunities
- Outreach to organizations that traditionally serve diverse communities, but do not regularly participate in community mental health
- Advertise to attract more consumer and family member involvement
- Make consumers and family members aware of opportunities to enter the employment system

### ***Supports for Consumers and Family Members***

- Provide ongoing accommodation and supports
- Ensure existence of Employment Assistance Programs
- Provide transportation

### ***Training for and by Consumers and Family Members and for Existing Staff and Partners***

- Involve consumers and family members in development of curriculum and training plans as well as instructors and peer mentors
- Training for line staff and managers that provide them the opportunity to discuss what their change in work environment is going to be like. Stamp out stigma.
- Share training among counties in the same regions

## **3. Education and Training for New Staff**

### **3.a. What strategies should be employed for training new employees?**

#### ***Training Methods***

- Promote mentorships. Implement structured, uniform training from an independent organization statewide.
- Counties could conduct trainings in advance of a job announcement, as a recruitment and training tool
- Provide more on-the-job training, classes and time off for classes
- Use a competency-based approach with agreement that people know what skills and competencies are expected. A broad group of existing staff is not familiar with this model.
- Emotional connection has to be established

#### ***Preparing the Work Environment***

- Provide appropriate accommodations beyond the scope of ADA: flex time, part-time, able to take personal leave and still have a secure job
- Revisit trainings on an ongoing basis, across the board, from mental health directors to all levels of staff, using an open-ended training approach

- Hold outings to museums and baseball games, etc. A good team not only works together but also plays together. This helps to break down hierarchy. Agencies can use an event planner to help with this.

### ***Staffing/Human Resources***

- New staff should be consumer providers, to try to make up for the deficiencies in past years. Their education should not solely be in social work (for example, sociology, anthropology, health sciences).
- Make hiring requirements less rigid, i.e., the number of years of work experience, degrees, etc. Add in or acknowledge the importance of life experience.
- Once a consumer provider has a foot in the door, s/he should not have to keep justifying her/his experience when going for promotions or next steps. There should be automatic movement up the career ladder without being tested, having to go through new requirements or education. Many people have test anxiety.

### ***Training Topics***

- Client-centered wellness and recovery practices vs. employee-centered treatment planning
- How to implement “full participation” services
- Help employers understand more than just mental health consumers. Teach them about physical health issues, co-occurring disorders, and dealing with the whole person. Integrate primary care with mental health services.

### **3.b. What are the most important training needs for new staff?**

#### ***Wellness and Recovery, Resources and Agency Philosophy***

- Agency values that drive agency services
- Education on health, wellness and recovery
- Orientation to all community services
- Comprehensive services planning

#### ***Communication Skills***

- Listening skills covered in first-year counseling courses. Good communication skills are crucial.
- Acknowledging that there are more similarities among consumers than differences
- How to appreciate co-workers at all levels of career path, all as colleagues. Encourage them to be less rigid about what is a career path or the need for certain degrees.

**3.c. What strategies need to be implemented to ensure consumer and family member involvement in the development of education and training plans?**

- Have consumers and family members conduct education and training sessions with people who understand adult learning
- Hire a consumer to help write and plan oral presentations for all training sessions and written materials so that lay people, consumers and professionals can all understand and appreciate the language used
- Include all levels of employees in discussion

**3.d. How can cultural competence be embedded in the curriculum for education and training of new staff?**

- Provide more cultural competence training for individuals. Explain exactly what cultural competence means and what it means for their job placement. Conduct outreach to other communities, such as Russians and people from the Pacific Rim.
- Encourage cultural groups to discuss among themselves what is important and to make recommendations to their agencies, rather than wait for recommendations to be brought to them. Hire people from that culture.
- Develop cultural awareness through exposure and self-assessment
- It is not possible to teach cultural competence, but it is possible to be open-minded. (Reference: DSM-IV, Cultural formulation from Dr. Frances Liu). It takes about three generations to acculturate to the U.S. This takes time, but in the meanwhile, mental health agencies need to do their best to train new employees to be aware and be able to work with ethnically diverse populations. There are very specific communities, so people cannot rely on general knowledge. There are trust issues within different communities, which can result in no-shows for appointments.

**4. Education and Training for Existing Staff**

**4.a. What strategies should be employed for training existing employees?**

***Target Groups***

- Provide training to Board of Supervisors; go to the Health Committee of Board of Supervisors and encourage them to talk to their peers. Their support is crucial in setting direction for the county.
- Train everyone at once, from the lowest level to management whose support is crucial to providing direction to staff
- Train professionals and administrators in wellness and recovery and peer-to-peer support
- Retrain people to do field-based study with older adults to increase understanding of their issues
- Create pathways for existing staff at all levels, including support staff
- Involve all in system, from receptionist to psychiatrist. Train management with clerical staff.

- Involve labor organizations to address practical issues. There is a tension about whether expansion will be contracted or staff-run.
- Provide training to clerical staff that are under-trained and on the front lines

### ***Training Time and Priority***

- Train early and often
- One-shot training will not work if the goal is to make the lessons stick
- Hold more than one-time events. Have ongoing interventions for all levels of staff including supervisors.
- Integrate training into the workday, balancing training with other responsibilities
- Provide adequate time for staff training. Most of the staff are already there but are drowning in high caseloads and paperwork. There is cynicism about administrative commitment.
- Retain existing staff by addressing morale. There need to be attitude and legal changes to accomplish this.
- Student loan forgiveness for existing staff
- Show how employee benefits from participating wholeheartedly, e.g., meets requirements for profession or other licensing and continuing education

### ***Training Topics and Curricula***

- Partner with education and encourage staff to take CASRA curriculum
- Investigate current models of evidence-based training practices and replicate them, for example the Village's immersion training
- Have employees examine their own biases and stereotypes
- Target training to assessment of existing staff and tie to their professional assessment of competencies. Target competencies to be developed.
- American Psychology Association (APA) has post-doctoral model for earning certification as specialists. There is no need to reinvent the wheel.
- Professionals need to learn flexibility and not be locked into traditional approaches

### ***Training Methods***

- Client and family members and other workers should work together to present trainings. Have clients and family members professionally trained as trainers.
- Engage existing staff in designing training so that they will own it
- Mentoring
- Long-term consultation of several cases, meeting weekly
- At the program policy area, look at the values of the organizations and institutions in terms of recovery and resiliency. These values will ultimately support staff providers.

## ***Other***

- There is concern and challenge that Medi-Cal rules are inconsistent with MHSA, but the revenue it provides is needed.

### **4. b. What are the most important training needs for existing staff?**

#### ***Training Topics and Methods***

- Cultural competence training on individual provider level to eliminate disparities
- Training on recovery and resiliency, with training delivered by consumers and family members
- Training on vision of MHSA: people should be steeped in this
- Use John Ott's "Four Quadrants of Change"
- Content and attitude: incorporate attitudinal barriers into training strategy
- Focus on outcomes overall
- Knowledge of co-occurring conditions
- Value of partnership of consumers and social workers, in understanding the value of both sets of competencies
- Collaboration with other systems, including education, family resource centers, regional centers, Department of Rehabilitation, Department of Social Services, etc.
- Job shadowing

#### ***Target Groups***

- Community partners such as law enforcement, education, county human resources departments and Boards of Supervisors all need training
- Expand training and vision to other systems, such as law enforcement
- Administrators and managers need training in changing the system
- Service delivery staff need to be able to make the shift from a patriarchal system toward one supporting recovery, appropriate use of 5150 and conservatorships, roles as helpers, notes, etc.
- Engage staff who already believe they are doing good on how to promote recovery and wellness without devaluing what they are doing now
- Support staff need basic information about mental illness, such as that provided by NAMI's family-to-family training
- Specific training for older adults, the largest group of unserved
- Training to meet needs of transition-age youth

### **4.c. What strategies need to be implemented to ensure consumer and family member involvement in the development of Education and Training plans?**

#### ***Support for Consumers and Family Members***

- Peer counseling for seniors. Start with focus groups and identify areas of interest.

- Provide transportation for consumers to increase participation
- Meetings for input should be more geographically available
- Develop career path for clients and family members working within the system
- Easily accessible offices
- Flexible schedules
- Provide funding, incentives and stipends to families to improve involvement, including child care, interpreters, American Sign Language, transportation, etc.

### ***Inclusion of Consumers and Family Members***

- Knowledgeable consumers should be at the table when training curriculum is developed
- Consumers and family members need to be involved in design of training
- Go to the Mental Health Board and NAMI and ask for consumer participation. For example, when administration gets a complaint from a family member, they should ask the family member if this could be used as a training example.
- Increase opportunities for consumers and family members to share their stories
- Outreach through PSAs, newspapers, television, radio and advocacy groups to reach more people

### ***Training of and by Consumers and Family Members***

- Fund strategies that will educate consumers to understand issues relevant to skills, competencies and curriculum. This should be pre-work to participating on “Curriculum Workgroup.”
- Consumers and family members need to be trainers
- Provide awareness programs for existing staff to best integrate consumers and family members as staff
- Provide family perspective in adult system and older adult system

#### **4.d. How can cultural competence be embedded in the education and training of existing staff?**

### ***Training and Outreach***

- Bring in leaders from underserved diverse communities to train, challenge current practice and provide options for integrating cultural competence into daily practices
- Train people at points of referral
- Involve all levels of education in this issue now
- Provide specialized training information on cultures. For example, take ten minutes at a staff meeting for individuals to share an example of their own language or brief description about their culture, food, etc.
- Provide cross-cultural opportunities on informal and professional level
- Link cultural competence with recovery and other best practices that require “meeting clients where they are”

- Staff and clients see themselves as different from each other. That applies to ethnic differences as well.

### ***Linguistic Competence***

- Current staff are not bilingual
- Make sure everything is in various languages
- Hire more multi-cultural, multi-lingual staff

### ***Organizational Commitment***

- The organization has to embrace cultural proficiency on an institutional basis, from the top down, to create organizational cultural competence
- Managers and those in leadership positions need to attend and participate fully in cultural competence training
- Tie cultural competence training to specific competencies for all levels of staff

### ***Broaden Definition***

- Include ageism in cultural competence
- Develop awareness in staff that diversity is more than ethnicity and language; it includes class, ageism, sexism and gender issues.

## **5. Rural and Small County Issues**

### **5. a. What strategies can be used to meet rural workforce education and training needs in California?**

- Over-arching principle should be that training and education must be based on the values and principles of the consumer movement
- County Mental Health should partner with community clinics and should cooperate through all aspects of client's illness and recovery. Address transportation needs by bringing the education to the clients, e.g., mobile classrooms in counties with large geographic distances.
- Train persons from the specific community through a combination of distance learning (videos) and local schooling through adult education, local high schools, and UC extensions
- Local educational institutions should provide mental health education and training
- Conduct regional monitoring of education programs for small county collaboration
- DMH must help by providing funding

**5. b. How can cultural competence be embedded in the education and training of staff in rural and small counties?**

- Hire clients and family members who are culturally competent and ethnically diverse as staff
- Develop a curriculum in cultural and client competence
- Train and hire qualified interpreters
- Outreach to Indian tribes throughout California
- Reevaluate existing training

**5. c. What strategies need to be implemented to ensure consumer and family member involvement in the development of Education and Training plans?**

- Conduct community outreach using community members as peer leaders
- Hire clients and family members to develop training plans
- Develop leadership and scholarship programs to encourage local people to develop these skills, including seniors
- Establish an Office of Consumer Affairs in County Mental Health Services, which should include Patient Rights Advocates
- Need something similar to a small county volunteer firehouse, a “community mental health firehouse,” someone who is always there but is also economical. This could include a community contribution, such as a Grange Hall. Hire local people who are peer-trained.

**E. Closing Remarks**

Ann Arneill-Py, Executive Officer of the California Mental Health Planning Council offered some closing remarks: the Mental Health Planning Council has been working on human resources since 2000. Its vacancy rate study showed a vacancy rate of 25% among critical professionals. Having found this degree of vacancies, the Mental Health Planning Council started to collaborate with DMH and CIMH, which led to its involvement in MHSA. The Mental Health Planning Council’s role in MHSA is to advise DMH on education and training, to review and approve the Five-Year Plan, and provide training and technical assistance. Examples of technical assistance can be found on the excerpt from a paper, *Consumer and Family Member Employment in the Public Mental Health System*, October 2003. This and other papers and reports can be found on the DMH website, which has a link to the Mental Health Planning Council. The Mental Health Planning Council was excited to have so many more people working on workforce development today than previously. This will move the effort forward in a positive direction.